SASKATCHEWAN PRESCRIPTION DRUG PLAN: A REVIEW

FOR THE

MINISTER OF HEALTH

Associated Health Planners

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INTRODUCTION

When the assignment to conduct an examination of the Saskatchewan Prescription Drug Plan (SPDP) was commissioned, it was understood that we would examine the Plan with a view to determing: how it was viewed by user, professional, and provider groups; how it compared with plans in other provinces; and how it met its original objectives. Our examination indicated that the Plan had, in most cases, met its original objectives; that it compared favourably in cost with plans in other provinces; that the user groups were generally satisfied with the benefit; that professional groups had concerns which ranged from mild to deep discontent; and that the views of the provider group, which includes manufacturers, administrators and distributors, ranged from unequivocal endorsement to outright hostility.

Considering the popularity of the plan among the general public, as well as its qualified approval by the professionals, and other interested groups, it was considered to be ill advised to recommend major alterations unless the economics of the plan proved to be unsound, which it was not found to be. Cost comparison showed only British Columbia with any cost advantage over Saskatchewan, and the remainder were less cost effective than Saskatchewan. That is not to say that room for improvement could not be found, but improvements that would drastically affect the user group, (82 percent of the families), or redirect the cost growth toward the pitfalls that other provinces are now experiencing, were not considered.

Chiefly among these, would be the introduction of a deductible plan, or any departure from the principle of "payment-for-drug-materials-at-acquisition cost". While it is true that all commentators favoured a deductible plan and that strong recommendations were made to reintroduce the effects of the marketplace into buying practices; it has been

concluded that it is too late for Saskatchewan to consider these options. Both premises are dependant upon a public attitude conditioned to a cost conscious consumer paying a full retail price at the point-of-sale. The Saskatchewan resident is not. He is conditioned to a small charge with each prescription. He has accepted paying a little more over the years, but is not ready for the full impact of total prescription costs, no matter how generous the co-insurance factor might be.

Hearings of, and meetings with, interested groups were held on as informal a basis as possible, where general discussion of issues was encouraged. Some provided formal presentations. Minutes of the hearings are included as Appendix A. In addition, representatives of academia, government and private plans, professional health care associations, as well as manufacturing and distribution concerns volunteered, or were sought out for, their opinions. A list of these contributors is included as Appendix B. The Saskatchewan Pharmacuetical Association (SPhA) submitted a brief which identified a number of outstanding concerns which may be found in Appendix C.

HOW THE PLAN IS VIEWED

Users

During the study, a cross-section of Saskatchewan residents was surveyed to determine their feelings about the Plan. Almost without exception, each individual contacted felt that the cost of a $3.75 prescription was reasonable and that no financial burden was placed on the drug plan users. As well, the Saskatchewan concept of universality and a standard co-payment was supported by The Provincial Consumers Association, the Senior Citizens Provincial Council and the Saskatchewan Association of Special Care Homes, all of whom argued against first dollar coverage and any differentiation of benefit between the independently-living and the institutionalized elderly. They strongly advanced concern for high and growing utilization, particularly among the elderly, and spoke in support of the medication review approach so successful in British Columbia. Furthermore, they appeared to see a deductible plan not so much as a cost saving device, nor as a deterrent, but more as a discipline to provider and user alike.

The pharmacist and the doctor, on the other hand, viewed the user attitude from the vantage point of the firing line, for it falls to them to deal with the patient when treatment will not be covered by the Plan. They spoke of what was not covered and what had been withdrawn. There was little evidence that what might be added to the Plan presented a major issue to the user, but what had been deleted certainly was an issue.

Throughout all the deliberations, it was observed that the user associated the cost of drugs with what he paid at the time the prescription was filled, and in Saskatchewan that meant $3.75. Only those who had lived in other provinces had any idea of the actual cost of drugs.

To sum up, with the exception of product deletion, user groups were well satisfied with the Plan, feeling it was affordable and responsible in its approach.

Professionals

The general feeling of the professionals was endorsement of the plan. Their concern centered around their overall role in the health care delivery system which they considered had been suppressed by the Saskatchewan Prescription Drug Plan (SPDP) bureaucrats. In relation to his fellows in other provinces, and to other professionals in the system, the pharmacist felt under-compensated. He felt trapped in a system where his professionalism and integrity were in question and where he has been relegated to the role of a simple mechanic.

The doctor, always sensitive to, and protective of, his independent professional judgement, viewed SPDP more as a potential threat than a specific problem. He was primarily concerned with how his prescribing practices had been, or might be, limited, through the Formulary and other regulatory matters; but more than that, he expressed a feeling of non-inclusion in many aspects of the decision-making process. He spoke of bureaucratic lack of interest and of tokenism in appointments.

The major commentators from academia were Doctors Gordon Johnson and James Blackburn (Head of Pharmacology and Dean of Pharmacy, University of Saskatchewan, respectively), both of whom confirmed general support of the Plan. On the matter of the Formulary, Dr. Johnson took the position of prudent selection of Formulary products and spoke of the quality of the SPDP Formulary, while Dr. Blackburn expressed concern over the minimizing of the pharmacists' professional judgement with respect to interchangability where SOC products were involved and, argued for the frontline professional as being the better judge of what should be prescribed and/or dispensed. They vociferously endorsed prudently-expanded use of available data, and pointed to the significant potential for research into scientific and quality-of-care issues. They felt the "potential was recognized by SPDP, but that the Plan had simply not gone about using the information to its fullest potential."

The essence of their concerns is one of attitude. Their memories are long, and the collision of the Doctors with, what they perceive to be, unacceptable unilateral practices, which precipitated the withdrawal of services, lingers on in the minds of all the professionals. Only visible recognition of their professional worth and greater participation in the ongoing development of the program will improve these attitudes.

Providers - manufacturers

The major issue concerning the manufacturers springs from Section 44 of the Patent Act, which allows compulsory licencing, whereby one manufacturer may be granted a licence to manufacture another's product prior to the 17-year protection granted all other products under the Patent Act.

The Pharmaceutical Manufacturers Association of Canada (PMAC) represents the 'innovators' who develop the products and who lose patent protection under this Section. The Canadian Drug Manufacturers' Association (CDMA) represents generic companies to whom licences may be granted. CDMA has prospered under this Section and wants the legislation to remain intact. PMAC, on the other hand, wants it repealed.

CDMA advances the position that Section 44 introduced competition into the industry; that it was conceived and passed in the interests of the public and provincial governments; and that it saves Canadians millions of dollars annually. PMAC argues that those savings do not offset losses to the economy in jobs, research activity, capital investment and increases to the trade deficit.

Innovators look to research and development as the life blood of their industry and point to reduction in overall health care costs through new drug therapies. They point to 1981 Canadian cost savings of $525 million in just six therapeutic categories as justification for their position.

Both manufacturers associations view SPDP as an extension of their feelings toward the Federal patent matter. While each of the provincial drug plans has benefitted from, and encouraged, the lower-priced generic houses, none has maximized the price difference potential more effectively than SPDP. The Standing Offer Contract (SOC) coupled with the non-substitution provisions of SPDP, represents the most confining of any drug plan. PMAC feels the Saskatchewan Prescription Drug Plan is its worst legislated arrangement, and fears its expansion.

For those in a highly competitive industry to encounter a sales obstacle is not unusual. In fact, problem solving and overcoming impediments is very much part of the game. To be legislated into a non-competitive position, or, out of business, as some see it, is another matter. The fact that hospitals often purchase drugs and medical products through a formulary and by tender, makes little difference to them. They have traditionally dealt with the vicissitudes of the market place and see the SOC tendering system as tinkering in that market place to the singular benefit of the generic manufacturers, and to the ultimate detriment of user, physician, pharmacist and themselves.

A growing school of thought has developed through this debate which is sympathetic to the PMAC position and hopes for some sort of compromise. It exists both inside and outside the province and includes Saskatchewan academia, the Saskatchewan Pharmaceutical Association and the Saskatchewan Medical Association. The debate appears to be reaching some conclusion with the announcement by the Honourable Andre Ouellet of his intention to revise the controversial section of the Patent Act.

Providers - drug plan administrators

Other drug plan administrators viewed the Saskatchewan plan with a mixture of envy and trepidation, but with the bias that would be expected to follow from the pecularities of their own plans. They tended to view it as administratively luxurious; a bit out of touch with the real world of the marketplace. Generally they were poorly informed on many workings of the Plan. Each questioned, with some wonder, why more wasn't made of the data base.

British Columbia, the recognized leader in the field of Drug Utilization Review (DUR), views the Saskatchewan data base as a vehicle of breakthrough for the work British Columbia had done, and is doing, to encourage the rational use of drugs. It credits its own success in curtailing program costs, in large measure, to reduced usage through the DUR and resultant programs. As well, British Columbia is the only province to support the Saskatchewan thesis of acquisition cost to the pharmacist as the basis of payment. British Columbia differs, however, in the method. Their reliance is placed solely on customers' impetus. The pharmacist must be guided by his competition price and continually seeks better prices from suppliers, the advantage accruing solely to the benefit of consumers and Pharmacare. In Saskatchewan the plan itself provides the impetus of cost confinement through restriction to the Formulary and the SOC tendering process. While certain philosophical differences do exist, the two plans are probably the most successful of those examined.

Manitoba has no information, other than claims payment data, for cash audit purposes. The nursing home, social assistance, and deductible plans are all administrated and funded separately. For report preparation, they have employed a pharmacy student during the summer and

whatever information is not gathered and presented during that period simply is not available. From the outset of both plans, there has been continuous communication with Saskatchewan. Evidently Manitoba holds a consistent posture of maintaining a basic third party payment plan. It is concerned that the "Saskatchewan philosophy" will spill over into Manitoba, demanding what they perceive to be, a far more expensive, higher-profile, and less desirable plan.

Ontario tended to look at broad universality, as did others, as a mistake, and was critical of Saskatchewan for introducing the concept. If directed to proceed along a similar path, Ontario would introduce a plan that did not compete with the broadly based industrial plans now in effect. It would want a substantial deductible and a restricted benefit package. It would be concerned that beneficiaries of existing industial plans would not demand inclusion, thereby transferring the present employer-paid costs to the public treasury.

Quebec relies heavily on the Saskatchewan plan as a source of information and a close personal working relationship between Dr. Gordon Johnson and Dr. Dennis Gagnon has developed through their formulary and drug assessment work. In Quebec, as in most other provinces, payment and resulting data, are dealt with through a sister agency, which employs systems primarily designed to provide payment and payment information. For a drug program that views itself primarily as a third party payment agency, that information is sufficient. Quebec, as British Columbia and Saskatchewan, views itself as more than that; more of a participating member of the health care delivery systems. It looks with envy at the Saskatchewan data base, and sees it as the only complete source of prescribing, dispensing and usage information in North America. Quebec was the only province to speak of the use to which it put the Saskatchewan Formulary. It has successfully challenged the pricing practices, for Formulary and reimbursement purposes, of some manufacturers, by using the Saskatchewan SOC prices to emphasize their arguement for lower prices.

A definite opportunity exists for a closer liaison with British Columbia with respect to information sharing both in the areas of drug utilization and cost of drug materials. As well, Quebec has a very clear window into manufacturers pricing policies which might be worth investigating as part of any cooperative information exchange.

Each of the provinces is concerned with rising prices and sees the Saskatchewan universal, non-deductible approach as a threatening concept. None really comprehends the effect of the limited benefits on Saskatchewan costs and thinks only of the cost of extending its own benefits universally without the deterrent of a deductible. British Columbia and Quebec tend to look on SPDP as responsible in its approach and attitudes, but perhaps a little too cautious in employing its data base in scientific and cost effective programs.

Providers - distributors

Examinations of the distribution aspect of the program brought out a broad range of varied opinion. The manufacturers who are geared for direct shipment spoke of the money that could be saved by SPDP in short cutting the wholesaler, while manufacturers who rely on wholesalers for distribution generally endorsed the system.

Feelings of pharmacists were very supportive of the wholesale system, although some did point to economics that could be affected through direct purchasing. Generally, they appear to be adjusting to the existing system where cost is not a factor in their purchasing practice and the use of a wholesaler simplified their accounting activities.

The attitude of the three wholesalers to SPDP could not be more divergent. National Drug viewed the unique Saskatchewan system as a regional difference to which it had adjusted. It did not feel the effect of competition in Saskatchewan as it did elsewhere, and acknowledged that its margin was assured through the cost plus arrangement SPDP offers.

United Pharmacists heartily endorsed the system and proudly pointed to its successful record of expansion, particularly since its elevation to wholesale status. It stated that the original complaints of pharmacists and wholesalers had been resolved to their satisfaction.

Prairieland was not supportive and pointed to a history of disagreement and inconsistancy of position with SPDP. It maintains that losses incurred because of the past inconsistancies have not been recovered and are still owing; and that the reduction in fee from 13.5 percent to 11 percent did not recognize the cost of carrying a full-time wholesale inventory, and had placed a hardship upon their continuing operation. It claimed that it responsibly maintained a full-line inventory of non-SPDP products, supplied any or all pharmacies without discrimination, as the Plan originally required, and that United did not, yet was paid the same fee for what was seen as a lesser service.

COMPARISONS WITH OTHER PLANS

Comparisons of the Saskatchewan plan to those of other provinces have been divided into two categories: program features, and program costs. The provinces included in our review are British Columbia, Alberta, Manitoba, Ontario, Quebec, New Brunswick and Nova Scotia. Comparative data was obtained from drug plan administrators and the Health Protection Branch.

For the purposes of this report, pertinent program features of each plan were compared with the Saskatchewan plan. General observations have been made and expanded upon when matters required further comment. Additionally, a brief outline of basic features for each plan have been included.

An historic review of the evolution of government drug plans might be helpful at the outset. After the provinces introduced hospital and medical plans, there was growing evidence of cases where patients, who could not afford the cost of drugs to stabilize a condition or correct a malady through a course of medication would often require expensive hospital treatment as a result. With the evidence of this need, and as funds became available, provinces developed programs to meet their individual needs, and subsequently revised and expanded them. In some cases, programs developed as an adjunct to, or part of, other social/medical programs. The net effect was a collection of varied programs, each satisfying, to some degree, the particular needs of the individual province. Saskatchewan's approach was total universality from the outset; British Columbia and Manitoba grew into their own form of universality; and the balance are not universal, but rather are targeted at the elderly, indigent, and special needs groups.

Program Features

While Saskatchewan, British Columbia and Manitoba each claim universality, each differs in definition. Each offers universal access, and only Saskatchewan asks for universal co-payment, except from those who cannot afford all or part of the co-payment feature. British Columbia and Manitoba vary co-payment for the under- and over-65 groups, and provide first dollar coverage to indigents. With the exception of Alberta, the other provinces have directed their programs to those groups which they consider to be disadvantaged (the indigent, the elderly and others), and cover only those (targeted plans). For the most part they waive co-payment and offer first dollar coverage. Alberta provides universal access to its Blue Cross Plan and pays all, or part, of the premiums for the elderly and low income groups.

Saskatchewan aptly identifies its program as a "Prescription Drug Plan" and not only restricts it to that, but also restricts coverage to its own product selection through the Drug Advisory and Formulary Committees. On the other hand, most other provinces refer to their plans as Pharmacare. As the term implies, the scope of coverage is broader and recognizes, for the most part, all prescription drugs, non-prescription drugs, and some over-the-counter (OTC) preparations. With the exception of British Columbia, the general benefit and first dollar plans are in danger of, or already are, exceeding all predicted or anticipated costs and the administrators of these plans are either considering implementing, or are attempting to implement, measures to achieve some control.

The manner in which each province recognizes the drug material component of the prescription for payment varies. Saskatchewan and British Columbia pay acquisition cost only. In Saskatchewan, acquisition may not exceed the Standing Offer Contract (SOC) price or the maximum allowable contract price set out in the Formulary. British Columbia has neither a formulary nor pre-set prices, but relies on the competitiveness and discounting of the market place to determine prices.

Alberta pays wholesale cost plus 25 percent markup. The balance of the provinces pay a formulary or retail price which is defined through a variety of methods. Shown in the table below are the methods used by each province.

DEFINITION OF DRUG MATERIAL COST AS LISTED BY THE HEALTH PROTECTION BRANCH

SASK	BC	ALTA	MAN	ONT	PQ	NB	NS
Actual Acquisition (to Formulary Maximum)	Actual Acquisition (Net, Net Discount, Rebate etc).	Wholesale plus 25% (Most Frequently Purchased Size)	Formulary or Smallest Package	Formulary	Liste de Med.	Formulary Net Cost to Pharmacy Customary Retail	Manufacturer Price (Nearest Package Size) Retail Less 40%

Costs of distrubution are built into the drug material costs in all cases. With the exception of Saskatchewan, the pharmacist buys, either directly from the manufacturer or through a wholesaler, in quantities of his choice. He is governed by a best-buy principle, since the margin on the drug materials is crucial to maintaining a competitive position. In Saskatchewan, direct buying is discouraged. In order to support the wholesale drug network, the Plan pays a fee for service of 11 percent to a wholesaler, and 7 percent to a warehouse.

Pharmacist Fees

In Saskatchewan and British Columbia, fees account for the total compensation to the pharmacist. In Alberta the pharmacist receives a fee plus 25 percent mark-up on drug material; and in the other provinces the pharmacist receives a fee plus whatever margin he might obtain through his own buying practices.

In Saskatchewan, the fee is partially paid by the recipient as his co-payment to the Plan, with the balance being paid as a subsidy from SPDP. To assist the smaller pharmacist, the fee is greater for the first 20,000 prescriptions and reduces thereafter.

In Quebec the fees are graduated. The Plan anticipates a basic fee for a 35-day supply, increases by 50 percent for any part of an additional 35-day supply, and increases a further 50 percent for any amount thereafter.

In all provinces, except British Columbia, the fee is negotiated with the provincial plan administrator. In British Columbia, the pharmacist sets his fee with his competitive position in mind. The Plan pays, within a average cost formula and, should the claim exceed that formula, the excess is deducted from the payment to the beneficiary, and explained as an excessive charge by the pharmacist. It is very rare, indeed, that the fee is excessive.

Shown below are the fees paid pharmacists in each of the sample provinces during 1982. Although out of date in some provinces, the data provide the most accurate comparison currently available,

PHARMACISTS FEES FOR PRESCRIPTIONS DISPENSED

SASK.	BC	ALTA	MAN	ONT	PQ	NB	NS
4.65 20,000 Rx	4.70 average	4.65	4.80	4.00	3.00 0-35 days	4.94	4.55 max.
3.60 thereafter					4.50 36-70 days		
					6.00 71+		

The fees paid by the Saskatchewan Prescription Drug Plan (SPDP) appear generally comparable to fees paid in most other provinces, but do not represent total compensation. It should be observed that total compensation cannot be determined until the effect of product mark-up is considered. In Saskatchewan and British Columbia, where only acquisition cost is allowed, this is not a factor. In Alberta it appears as an across-the-board 25 percent mark-up. Accurate margins realized by pharmacists in the balance of the provinces are not easily obtained, as they are combined with the drug material costs in most data available.

The Saskatchewan Pharmaceutical Association (SPhA) argue, very effectively, the plight of the Saskatchewan pharmacist in comparison to his colleagues in other provinces.

It complains of less than cordial negotiations in the past and looks for an alernate means of determining fees. It proposes two possible solutions. First, allow the pharmacist to set his own fee in consultation with SPDP - a process which would alter the process from one of negotiation to one of consultation. Secondly, SPhA recommends that drug costs be redefined to acknowledge the cost of carrying, and the cost absorption of his inventory by granting a percentage markup on the formulary price or acquisition cost. As well, SPhA recommends the reduction in fee for prescriptions in excess of 20 thousand per annum be abolished.

From all evidence, particularly from other drug plan administrators, there appears to be little doubt that the Saskatchewan pharmacist is grossly under-compensated when compared to his counterparts, and that the inequity lies within the area of product markup to cover inventory investment and carrying costs. The Association advances strong and convincing arguement for recognition of this cost factor and point to wholesaler/warehouses "up charge" as a substantial precedent for their case.

Eligibility, Benefit Limitations and Deductible Provisions

Since provincial plans do not maintain data from which these program features may be identified and extracted for separate consideration, the features have been examined in the aggregate. The following table identifies eligibility, prescription frequency and cost, and demonstrates the impracticality of any general comparison. Examination of the data merely tend to prove the obvious in showing:

- that the non-universal plans cover only 10 to 16 percent of the population.
- that the non-universal plans, targetted to the elderly and indegent, have substantially higher use and cost; as much as 3 and 4 times, respectively.
- that Saskatchewan cost per population is the highest because it universally covers payment without deductible.

Scope of Plans (all beneficiaries)

	SASK	BC	MAN	ONT	PQ	NB	NS
Population (000)	980	2,711	1,031	8,625	6,345	711	857
Eligible Beneficiaries (%)	96	92	95	10	16	11	11
Active Beneficiaries (%)	67	18	20	85	85	83	90
Average Number of Prescriptions	6.7	9.6	5.7	18.1	19.6	18.4	21
Cost/Active Beneficiaries ($)	46	95	53	146	157	196	222
Cost/Population ($)	27	16	10	18	21	17	20

The following was prepared to illustrate the differences in the over 65 group between the Saskatchewan Plan, which has a co-payment limited benefit feature, and plans which have first dollar coverage and expanded features.

The table identifies the percentage of the population over 65 as eligible and active beneficiaries, and the prescription frequency and costs. Examination of these data would suggest substantially lower use and lower cost per beneficiary in Saskatchewan.

Scope of Plan (over 65 group)

		SASK	ONT	PQ	NB	NS
Eligible Beneficiary	(%)	12	10	9	*	11
Active Beneficiary	(%)	10	9	7	*	10
Average number of prescriptions		15	23	27	19	20
Average cost per active beneficiary	($)	117	217	218	224	240

*Data Not Available

Utilization

From the data available, utilization was examined by comparing the percentages of the population eligible for benefits, the percentage of eligible beneficiaries who were active beneficiaries under each plan, and the number of prescriptions and costs for these groups. Further analysis of the table below shows:

- a substantial number of potential beneficiaries in Saskatchewan do not use the Plan - 96 percent eligible; 67 percent active.
- a very high utilization in specifically targeted plans - 83 to 90 percent.
- a substantially higher volume of prescriptions among targeted groups - Saskatchewan 67 active beneficiaries compared to 18 in targeted groups.
- substantially higher cost per active beneficiary in target plans - Saskatchewan 46 dollars compared to 146 to 222 dollars in targeted plans.
- substantially lower cost per population when a universal plan is subject to deductible - Saskatchewan 27 dollars; British Columbia and Manitoba 16 and 10 dollars, respectively.

Scope of Plans		Deductible			Targeted			
		SASK	BC	MAN	ONT	PQ	NB	NS
Population	(000)	980	2,711	1,031	8,625	6,345	711	857
Eligible Beneficiaries	(%)	96	92	95	10	16	11	11
Active Beneficiaries	(%)	67	18	20	85	85	83	90
Average Number of Prescriptions		6.7	9.6	5.7	18.1	19.6	18.4	21
Cost/Active Beneficiaries	($)	46	95	53	146	157	196	222
Cost/Population	($)	27	16	10	18	21	17	20

Drug Material Costs

Drug cost comparisons were made by using the top 50 interchangeable groups in descending order of cost to SPDP, for the thirteenth formulary period ending 31 December, 1982. All products listed within each interchangeable group were identified, and the dispensing volume for each was determined from SPDP operating data. To this constant, the price paid by each plan for each product was multiplied to give comparative totals of what Saskatchewan actually paid as opposed to what it would have paid if it had used the other provinces' pricing arrangements. Comparison was then possible by grand total, group total, or individual product.

A comparison of Saskatchewan's total drug material cost to the costs of the other provinces shows British Columbia 9 percent lower than Saskatchewan, Alberta 26 percent higher, Manitoba 10 percent higher, Ontario 14 percent higher and Quebec 2 percent higher. Complete data for New Brunswick and Nova Scotia were not available at time of writing.

DRUG MATERIAL COSTS FOR THE TOP 50 INTERCHANGEABLE GROUPS
(BY DECENDING ORDER OF COST) IN 1982

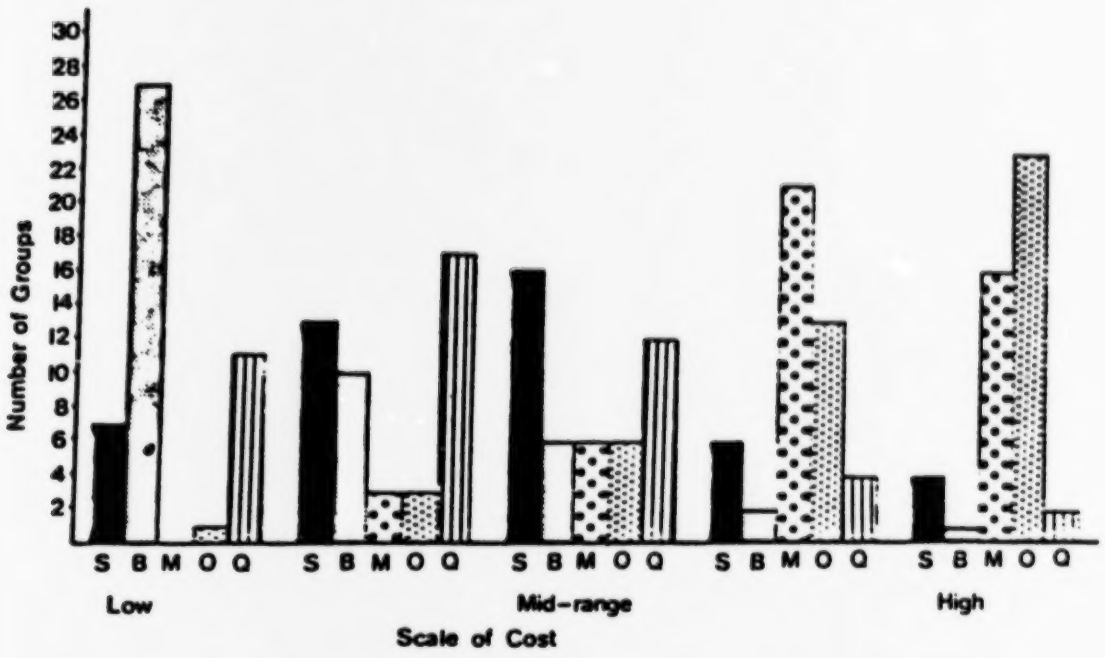
SASK	BC	ALTA	MAN	ONT	PQ	NB*	NS*
11,329	10,475	13,939	12,309	12,763	11,509		
Higher-(Lower) Than Sask	(9%)	26%	10%	14%	2%		

*Data Not Available

Further examination was made to determine the high/low range of each of the 50 interchangeable groups. Standing Offer Contracts (SOC) were in place in 19 of these groups and were examined separately. Because Alberta showed a high position in 29 of the 50 groups (58 percent), it was decided to grant it high position and omit it from further examination.

This approach allowed for a more accurate examination of the provincial prices for a more meaningful price spread. The following graph identifies the high/low range.

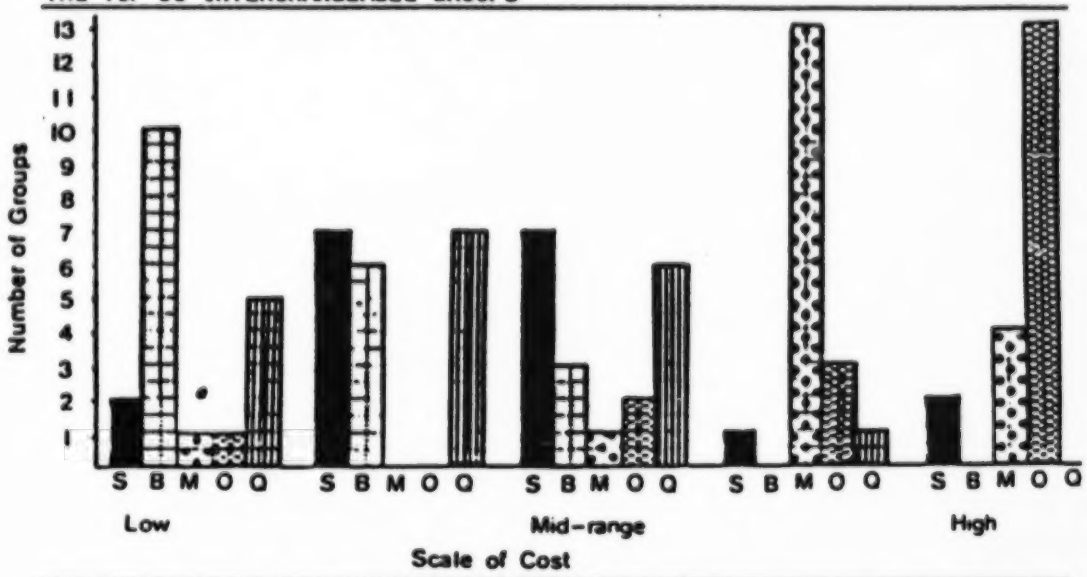
LOW/HIGH COST FREQUENCY OF THE TOP 50 INTERCHANGEABLE GROUPS IN THE FIVE PROVINCES



	SASK	BC	MAN	ONT	PQ
LOW	7	27	-	1	11
HIGH	4	1		23	2

A cost analysis of the SOC interchangeable groups was conducted by taking the cost of the SOC product, then taking the cost of the equivalent innovator's product, and then adding them together to arrive at a total for the group. This was done for each group. By this means the constant was the Saskatchewan volume, the variable became each provincial cost. High and low costs positions have been reported below.

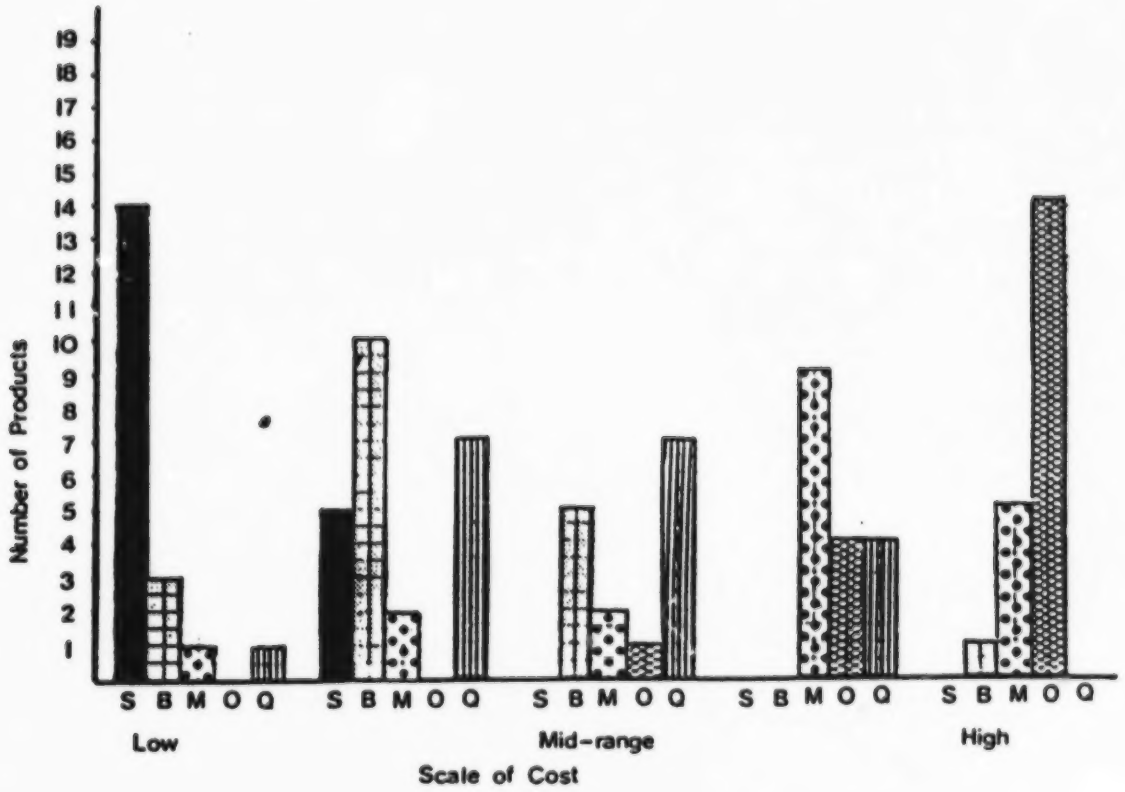
LOW/HIGH COST FREQUENCY OF THE 19 SOC GROUPS AND THEIR PRODUCTS WITHIN THE TOP 50 INTERCHANGEABLE GROUPS



	SASK	BC	MAN	ONT	PQ
LOW	2	10	1	1	5
HIGH	2	-	4	13	-

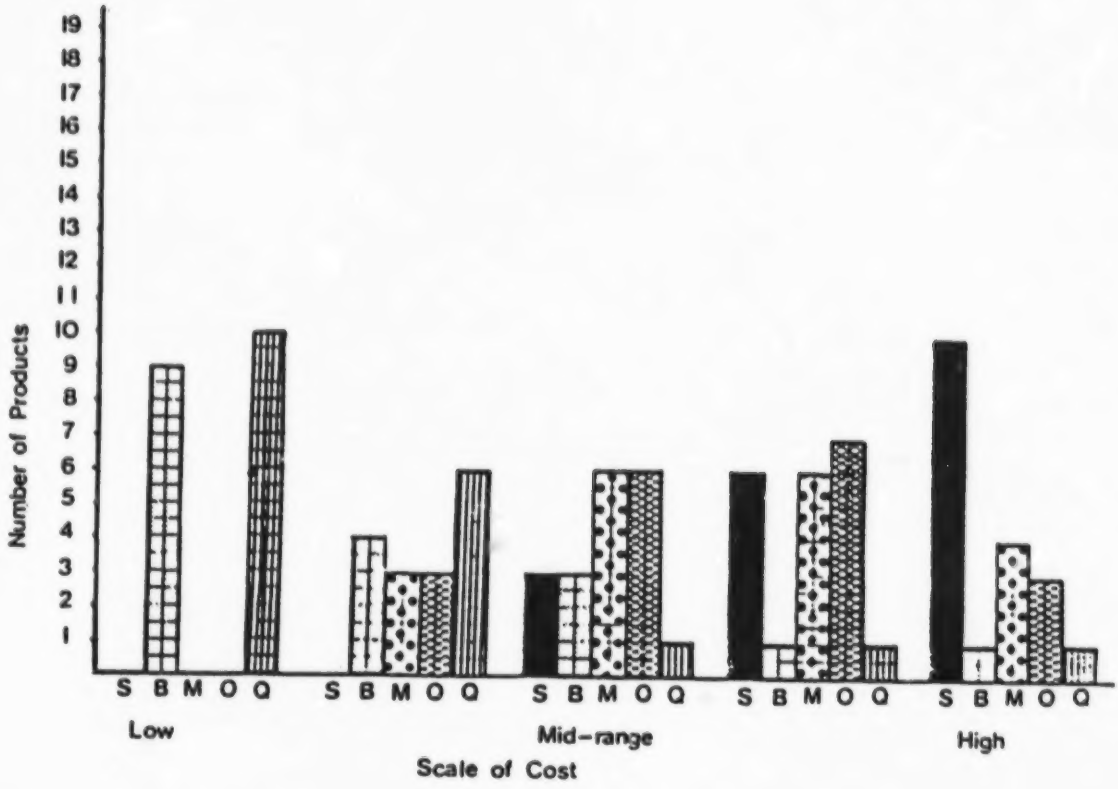
In examining Saskatchewan's position, it might be concluded that the SOC had effectively pared generic prices to the lowest in 14 of 19 cases (75 percent), but when Saskatchewan's price of the innovator's product was considered, that position was only sustained in 2 of the 19 cases (10 percent). When innovator's products were considered, Saskatchewan was highest in 10 of 19 cases (53 percent). The following two graphs show the break down of the low/high cost frequency of the SOC products and the innovators products within the SOC groups.

LOW/HIGH COST FREQUENCY OF THE 19 SOC PRODUCTS WITHIN THE SOC GROUPS



	SASK	BC	MAN	ONT	PQ
LOW	14	3	1	-	1
HIGH	-	-	5	14	-

LOW/HIGH COST FREQUENCY OF 19 INNOVATORS PRODUCTS IN THE SOC GROUPS



	SASK	BC	MAN	ONT	PQ
LOW	-	9	-	-	10
HIGH	10	1	4	3	1

Cost Containment Features

In Saskatchewan cost containment is approached through regulatory control by SPDP and is practiced through the restriction of benefits to prescription drugs only; the use of a restricted Formulary; the Standing Offer Contract (SOC) tendering process; and the broadest use of a co-payment feature. These practices allow the Formulary Committee to include and exclude products, and SPDP to select product for tender. Although some would argue, the almost universal application of the Saskatchewan co-payment feature serves to effectively reduce utilization over first dollar plans. While these practices provide the maximum of control, they sacrifice all impact of the market place as a cost containment factor. As well, the cost containment features that flow from market fluctuations within interchangeability groups are essentially lost because of the SOC process which requires the mandatory dispensing of the low bidder's product.

British Columbia is the antithesis of Saskatchewan. There, the plan is regulated as little as possible. It relies on two different sources of containment; the market-place, and the professional bodies. Since the standard benificiary pays the full retail price at the point-of-sale, it is incumbent on the pharmacist to maintain a competive price point. His buying and dispensing practices are governed by this overriding objective. He maximizes the latitudes granted to him by product selection legislation, but, only in British Columbia are these advantages directed exclusively to the consumer and to the plan.

This is achieved by restricting the payment of the pharmacist to acquisition cost for drug materials; payment by the plan of an average cost formula; and the pharmacists recognizing a standard of practice requiring the same price for all, irrespective of from whom the payment might be received.

It is in the area of Drug Utilization Review (DUR) that further cost containment is anticipated in British Columbia. This program is run by the professions, not the plan. Their associations endorse the ethical standard that states, "the better the prescribing and dispensing practices, the better the health care". This leads to peer review of those practices and ultimately to fewer prescriptions, thus fewer claims to the drug plan.

Manitoba, like British Columbia, requires a deductible from their standard beneficiaries and, therefore, the principle of the market place applies equally to consumers in Manitoba as it does to those in British Columbia - the difference being that the plan recognizes a retail price, rather than acquisition cost, for payment. The fact that the mark-up is substantially greater on formulary drugs, as opposed to non-formularly drugs, (170 percent to 67 percent), is a good example of the marketplace at work, but not to the benefit of the third party agency. The formulary price merely sets the starting point from which pricing competion begins.

Cost containment for claims on behalf of first dollar beneficiaries is at best complex, as they are administered by two government departments, as well as the City of Winnipeg, where pricing differences are accepted. Administrators see their role as claims processors and they adjudicate on the eligibility and accuracy of those claims only.

The attitude of the Health Care Insurance Companies who underwrite industrial plans was interesting. They saw themselves simply as "contract administrators" with no responsibility for cost containment. They saw their role as one of merely receiving and the payment of claims on a plan whose benefits were determined by the employer, not the underwriter, and, in most cases, was part of a collective agreement. The premiums were set to cover claims plus retention, (administrative charges), and if those components increased so did the premiums. In their view, cost containment factors were a function of the agreement between the insured parties. If the premiums increased, the parties had a choice of paying them or changing the contract in such a way to reduce them. The parties determined the risk, they simply administered it.

With the exception of the Alberta Blue Cross program, the other provinces rely basically on formulary pricing and product selection legislation to contain costs. They tend to function more as third payment agencies than does Saskatchewan.

MEETING OBJECTIVES

It is our understanding that the Saskatchewan Prescription Drug Plan was established to:

- reduce the direct cost of prescription drugs to Saskatchewan residents.
- provide coverage to Saskatchewan residents for quality pharmaceutical products of proven therapeutic effectiveness.
- reduce the cost of drug materials by encouraging effective price competition and quantity discounts.
- encourage the rational use of prescription drugs through research, consultation with professional associations, and educational programs directed at physicians, pharmacists and the general public.

With respect to the first objective, it was perceived that the intent of the statement was to extend beyond a one-time initial reduction, and to anticipate continued low costs to the resident. This was found to be the case as the following analysis will show:

- Between 1977 - 1982 the user portion of drug costs increased to 12 million dollars from 7 million dollars, or 61 percent while the total cost of the program increased to 33.8 million dollars from 16 million dollars, or 103 percent.

- In 1977-78 the user portion was 33 percent of the total cost and decreased by one percentage each year to a ratio, in 1981, of 30 percent (user) - 70 percent (SPDP), where it remained in 1982.

- The user has consistantly paid approximately 30 percent of each prescription cost from the first prescription since the inception of the plan.

In examining other plans which claim universality, comparison must be made to first dollar coverage and deductible features. In British Columbia and Manitoba, the deductibles for persons under and over 65 years of age, are respectively, $125 and Nil; and $75 and $50; each with an 80-20 co-insurance factor thereafter. Residents of long-term care facilities and personal care homes are afforded first dollar coverage. Other provincial plans are aimed at the over 65 and disadvantaged persons, where first dollar coverage is the rule.

Compared to first dollar plans the cost to Saskatchewan residents are higher. Compared to deductible plans, the cost to Saskatchewan residents is lower for the minimal user, but higher for the heavier user. The Saskatchewan beneficiary pays 30 percent of every prescription while the British Columbia resident pays 100 percent of all prescriptions until the deductible limit of 125 dollars is reached and then 20 percent of all cost thereafter. The Saskatchewan beneficiary is better off until prescription costs of 900 dollars is reached at which point the situation reverses.

As to the second objective, there seems little doubt that it has been met. In fact, criticism came the other way, suggesting that SPDP was too zealous and restrictive in product selection for its Formulary. The Drug Assessment Committee, the Formulary Committee, and in particular Dr. Gordon Johnson, enjoy a reputation for the production of a limited but superior Formulary of pharmaceutical products of proven medical effectiveness.

With respect to the third objective, the comparison pointed out that it had been substantially met, but not through the means initially contemplated. The objective anticipated the "reduction of drug material costs by encouraging effective price competition and quantity discounts." Of all the provinces, only in British Columbia do competition and discounts favourably impact upon the Plan. Saskatchewan, instead, has effectively arrived at an enviable second place position by maximizing the use of low-cost generics and minimizing the use of innovators' higher-cost products by means of its "Standing Offer Contract" (SOC) tendering method; the curtailment of interchangeability of SOC products; and the use of the no-substitution provision to doctors' prescriptions. Results achieved through these practices may not be credited to effects of the market place.

The fourth objective concerns the rational use of drugs, research and education. Original suspicions that Saskatchewan was a repository of extremely valuable resource material and personnel, which was under-utilized and under-employed, was confirmed by observations of many credible commentators, from both inside and outside the province. The outsiders spoke enviously of the sophisticated administrative vehicle, uniqueness and completeness of the data base, and the quality and dedication of many of the contributors to the SPDP team. The insiders spoke in terms of disappointment with the under-utilization.

While no one suggested any area of shortcoming or negligence, with respect to the rational use of drugs, research or education; a substantial constituency spoke of the under-utilization of this valuable resource and the role Saskatchewan should and could play in a larger community, contributing to the broader arena of joint research ventures with other provinces and, indeed, to world health.

PUBLIC ACCOUNTABILITY

Public accountability for cost reimbursement must be provided through the strength of the audit procedures. Historically, problems over the audit procedures have existed since the inception of the plan. Apparently there were some initial difficulties when existing inventories were carried forward and a number audits uncovered old stock being charged out at formulary price instead of acquisition cost. Since that time both SPDP and the pharmasists have worked out reasonably satisfactory arrangements for the disposing of redundant inventories when a new formulary is published.

However, the resolution of the initial start up difficulties apparently have never resolved the real issue between both parties which is the audit procedure itself. The stated purpose of the audit procedures is "to ensure that the Drug Plan is charged no more than acquisition cost" by the Pharmacist. By operating within the strict letter of this principle there was room for error on only one side, the pharmacists, and no latitude was given to granting credits for underpayment made by SPDP. That is not to say no underpayments were recovered, but the process was arduous and demeaning. The Pharmacist is of the opinion that the audit should take into account the debits with the credits and that he should be compenstated for SPDP errors in the same way as SPDP should be compensated for his. SPDP did not see it that way and very strong feelings have resulted. Presently the matter is in limbo.

To insure that a high measure of public accountability was in place, the Bureau of Management Improvement was called upon by SPDP for an appraisal in the fall of 1982 and reported the following findings:

- overpayments of the first five formulary periods were $619.000 from 301 audits.

- error rate: Period 1 - 3.07%
  2 - 3.33%
  3 - 2.49%
  4 - 1.58%
  5 - 1.09%

- 136 audits of periods 10 through 13 yielded $10,800.
- the value of possible underpayments appears relevant. Examples:

	Example I		Example II		Example III	
Period	Over	Under	Over	Under	Over	Under
1	$517	$249			$381	9
2	656	120			363	18
3	327	217			82	68
4	200	225	$467	66	55	77
5	169	125	218	8	28	70
6	184	56	155	137		
7	30	116	362	136		
8			63	100		
9			252	94		
10						
11						
	2,085	1,109	1,517	545	910	242

From the above findings it would appear that the cost benefit of ongoing audits is in some question and might be replaced with spot audits; and the case of the pharmicist for under-payment recognition could be easily incorporated into any new procedures.

When one considers that SPDP has a record of every item for which a pharmacist claims, and also has access to his purchasers through wholesale invoicing it would appear a rather simple process to marry these two factors and determine where audits might be appropriate. British Columbia does it very effectively with only a fraction of the data available to Saskatchewan. There the discipline for infractions revealed through audits is administered by the Association not the Drug Plan.

From the available evidence it would appear that the claims processing system is, to a large extent, self auditing, and that public accountability is not in great jeopardy. This does not eliminate the need for audit, but would dictate the form the procedure should take. Except for long standing resentments and frustration over unsolved issues there was no reason voluntered why the parties could not have resolved this issue years ago. The matter should be resolved, and resolved quickly. It is recommended that they be instructed to do so and to report matters upon which they cannot reach agreement to the Minister for adjudication. It is our opinion no matters will reach the Minister.

DRUG USE AND CONTROL IN SPECIAL CARE HOMES

The Saskatchewan Association of Special Care Homes (SASCH), the Saskatchewan Pharmaceutical Association (SPhA) and the Saskatchewan Prescription Drug Plan (SPDP) are in the final stages of completing their findings on the Standards of Pharmaceutical practice in Special Care Homes.

Since the "Purposed Model for Pharmacy Service in Special Care Homes" was prepared in March of 1982, the three parties have studied, and where possible, have adopted, the system used by Long Term Care Facilities and British Columbia Pharmacare. Although a final report of their findings and recommendations has not been completed at the time of writing, and therefore cannot be reported on, the briefs presented by SPhA and SASCH propose recommendations which are supportive of each other and from which a concensus of standards and services may be established. It appears that certain administrative details with respect to program administration, and the compensation package to the pharmacists remain unconcluded.

The major objective in reforming pharmaceutical services in special care homes, is to assure better care through an effective system of monitoring drug consumption by residents. To achieve this end a team approach was proposed which would involve professional and lay staff, both within the home and outside the home.

The system contemplates a single pharmacist who would provide, in addition to his dispensing service, a professional monitoring and information service. He would maintain patient profiles, employ a monitored dose system, and conduct educational programs within the facility. Each home would establish a Medication Safety Committee, maintain effective charting of all medication and provide in-service training for both professional and lay staff. Attending physicians would be invited to participate in the regular review of the patient profiles and charts of each resident, and to participate in the educational program.

The system employed in British Columbia appears to be a simple and effective model. Pharmacare data for the first three years of its program illustrated that 17 thousand facility residents received an average 7 prescriptions annually. Ambulatory patients in the same group received only 10 prescriptions annually. Within 18 months of the introduction of a medication review program, costs in facilities had declined by 30 percent and the average number of prescriptions was reduced by 45 percent.

The British Columbia medication review program is essentially the same as what has been outlined earlier. However, it has an additional feature in that the fee for services has been replaced with a capitation payment, where the pharmacist is compensated by stipend rather than a charge for each prescription. Since a major part of his role as team leader is to reduce the number of prescriptions used by this often over-medicated group, this method of payment does not penalize the pharmacist for his accomplishments. The program has been so successful that the cost of pharmacy services, based on the capitation rate, exceeds the level that would be experienced if a fee for service were in place. However, the provision of the expanded services provided by the pharmacists, vital to the reduction of prescriptions, far outweighs this modest outlay. British Columbia estimates a current net saving to its plan of 4.5 million dollars per annum. SPhA endorsed both the principle of capitation and of the single pharmacist within submission.

It should be carefully noted that British Columbia identified the responsible role accepted by the professionals as the key to the success of the program. Through the Drug Use Review (DUR) program a committee of medicine and pharmacy determined appropriate standards of drug use and asked the University of British Columbia to analyze data and provide recommendations, on which continuing education and seminars could be based. By allowing the professionals to write the rules, a professional

commitment has evolved, which has resulted in far more stringent standards than pharmacare had imagined. Professional surveillance has been extremely effective, as the physicians and pharmacists view the program as a child of their own creation; its success a professional reward, and its prudent surveillance a matter of honour.

THE ROLE OF SPDP AND THE PROFESSIONALS

Every commentator directed his displeasure against SPDP, not against the present government, not against the previous government, but against SPDP. It is seen as a philisophical concept, immuned from any critisism, contructive or otherwise. A concensus spoke of their dealings with SPDP as completely predictable; no matter what they did or said, SPDP would maintain its doctrinaire course unswervingly.

The track record of SPDP points to a number of laudable achievements which in the doing have made it more enemies than friends. One cannot overlook the fact that drug costs are substantially lower than anywhere else in Canada, except British Columbia. By maximizing the use of generics through restricting the professionals in product substitution, and with the restrictive Formulary; SPDP has unquestionably kept costs in line. While this philosphy endeared SPDP to those who profited substantially by it, chiefly the generic manufacturers; it alienated the innovative manufacturers and the professionals.

SPDP critics now say that it was not so much what SPDP did, but how it did it. They now complain more of their treatment and their status than of the concept. That being the case, the issue becomes more attitudinal and less doctrinaire, for which a remedy can be found without throwing the baby out with the bath water.

The professional should and could be the front line advocates, if their attitudes were changed. There is no question, the Plan has been a godsend to their practices and touches the public every time a prescription is filled.

They claim to endorse the Plan, but not the treatment they receive, and list a score of items, none of which has any major effect on the health of Saskatchewan residents; but each of which is worthy of consideration and deserving of discussion. The fact that many of these items date back to the inception of the Plan only confirms their suspicions that

their point of view is of little value in the scheme of things. These matters are itemized in the Associations submissions which form Appendices to this report, and will be incorporated in the SPhA negotiations demands for 1984.

The commissioning of this review has gone a long way in alleviating their frustations. A restructuring and upgrading of the professional role so that it will result in a supportive force, is vital to the success of whatever course is eventually decided upon. Essential to these new roles will be a well developed and structural communication system which will not only allow professionals and other interested groups to be heard, but will allow them to accept professional and association responsibility for their contributions and actions.

CONCLUSIONS AND RECOMMENDATIONS

Program Benefits and User Co-payment

Conclusions

- The Saskatchewan Prescription Drug Plan, in its present form is a highly popular program with the public, and any drastic realignment of benefits or payment methods would be veiwed by the public as a substantial loss of benefit.

- The expansion of the Formulary is a major issue with manufacturers, a minor issue with professionals, but a non-issue with the public.

- The deletions from the Formulary particularily of Cough and Hemorrhoidal preparations are an issue with pharmacists and those who have lost the benefit.

- The partial payment for each prescription by the elderly is a non-issue, and strong representation was advanced against providing first dollar coverage.

Recommendations

- Maintain the program benefits without expansion into non-prescription drugs and over-the-counter (OTC) products.

- Maintain present user payment arrangement for all classifications of beneficiaries with future consideration given to initiating a catostrophic cost provision which would refund the user a portion of his costs over a certain annual maximum.

Saskatchewan Formulary System

Conclusions

. The existing formulary system adaquately provides for the prescription drug needs of Saskatchewan residents, and acts as an extremely effective cost control.

. The Standing Offer Contract (SOC) tendering system is intensely opposed by the innovative manufacturer whose product sales have suffered substantially from generic competition. The system is heartily endorsed by the generic manufacturers who prosper under a price only criterion.

. Analysis of SPDP cost data, and corresponding data in seven other provinces, brings the matter of the cost effectivness of the SOC system into serious question, when one determines that in only 2 of the top 19 interchangeable groups, where SOC were awarded, were the Saskatchewan costs the lowest in the sampling. The analysis showed that in 5 cases out of 19 the SOC tender price was undersold elsewhere in Canada, and that in 10 of the 19 groups, the innovator price was the highest charged in the sampling.

. The restrictions of payment for drug materials at acquisition cost is a major cost containment feature of the program.

. The analysis identified British Columbia as the most cost effective plan, being 9 percent lower than Saskatchewan in total drug material costs. In that

province payment is based on an average actual acqusition cost of drug materials. Even though prices are lower in British Columbia than in Saskatchewan, drug companies favour that system over the SOC system.

. The Pharmaceutical Manufacturers Association of Canada (PMAC), the association of innovative companies, have wide support for some greater protection for new products from generic competition and have offered comparative price monitoring, and redirection of research and educational funds in return for more favourable consideration.

Recommendations . Maintain the present formulary system intact, but explore alternate purchasing methods which would replace the SOC system with one in which incentives for best buy principles could be introduced.

. Enter into formal discussions with PMAC to determine the seriousness and extent of its proposed commitment to comparative pricing, and research and education funds in exchange for extention of new product protection.

Dispensing Compensation To Retail Pharmacists

Conclusions

. The Saskatcahewan pharmacist stands alone in his compensation arrangement when compared to his colleagues in other provinces. Unlike his contemporary in British Columbia whose fee is set in the market place, the Saskatchewan pharmacist's fee is set through negotiation with SPDP. Unlike pharmacists in all other province, except British Columbia, he is disallowed a margin of mark up on his drug material costs. Evidence was sufficient to show him historically well behind pharmacists in other provinces.

. The Saskatchewan Pharmaceutical Association (SPhA) advances two possible arrangements to bring them in line, not only with fellow pharmacists in other provinces, but also with other health care professionals in Saskatchewan. It first proposes that the pharmacists' fee be allowed to float, without the benefit of subsidy, as it does in British Columbia. Alternately, it recommends some consideration be given to the financing of the pharmacists' inventory through mark-up or margin consideration. The pharmacists presently have such an arrangement with both the Departments of Indian Affairs and National Defence, and include a mark-up in charges to non-drug plan patients.

Recommendations

. There should be no departure from the acquisition cost formula of payment for drug materials.

. To remove the subsidy and allow the dispensing fee to float would have the effect of transfering the full cost of prescriptions,less the drug material cost, to the beneficiary at the point-of-sale. This proposal could cause the fee to increase as much as 2 dollars, which would unquestionably be resisted, and viewed as a severe loss of benefit. This option is not recommended unless provincial finances dictated reduction to overall health benefits.

. The second option provides much more scope for an enduring relationship. Argument may be advanced for overhead costs to be borne out of what may be considered a gross fee, but financing of an inventory as well, is not as convincing an argument. Precedent would be hard to find where both sources of revenue, the fee and drug material costs, are fixed by the payment agency; which at the same time is requiring the carrying and maintenance of an expensive inventory. It is strongly recommended that this alternative be pursued in upcoming negotiations.

Use of the SPDP Data Base for Scientific Purposes

Conclusions

. The method of administering the Saskatchewan Prescription Drug Plan has produced remarkably complete patient drug profiles and dispensing records for any given product. Because access to the Plan is completely universal, its data base covers not only certain targeted groups of the population, but vertually all the population of a million people. These factors make it unique in North America and of great importance for a variety of scientific purposes.

. Although some use has been made of it in identifying abuses of mood modifying drugs, it is the general concensus of all informed observers (including SPDP and Saskatchewan Health Officials) that its potential is virtually untapped.

. British Columbia has a proven track record of better health care and redcued costs through its DUR program. Its success has been through the involvement and commitment of pharmacists, physicians and academics. The process is ongoing. As protocols are developed, potential problems identified, and reviews targetted the result is the same, fewer prescriptions and less cost.

. The field of post market surveillance is in continuing need of the means of tracing prescribing and dispensing practice for scientific follow-up. The cost to the manufacturers establishing the follow-up

system is staggering and SPDA has one in place. There is opportunity to attract co-operative past marking surveillance projects, which would both contribute to world health and provide a flow of funds which could more than offset administrative costs.

Recommendations

. Introduce a high profile Drug Utilization Review (DUR) program in conjunction with the professionals and the manufactures which would be directed at public awareness of the hazards of over- and under-utilization, and self-diagnosis.

. Establish an information network through which physicians and pharmacists may retrospectively review patient profiles in relation to utilization criteria established by the professional bodies.

. Commission a select committee of physicians, pharmacists, academia, and departmental officials to determine acceptable parameters through which drug plan data may be released for scientific research, which would create a flow of research funding into Saskatchewan.

. Further explore the potential use of the drug plan data capability in the field of post marketing surveillance with the Innovative Manufactures, the Health Protection Branch, and other responsible bodies who might properly employ the information with adequate compensation being provided to SPDP.

. Establish a working arrangement with British Columbia to share data and to co-operat with DUR, and related educational and professional matters.

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